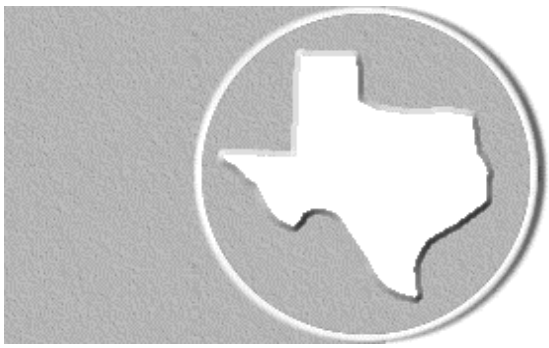

TEXAS
STATE
STRATEGIC
HEALTH
PARTNERSHIP

WORKGROUP HANDBOOK

February 2003

For the latest information about the Partnership, visit the website:
http://www.tdh.state.tx.us/dpa/sshp.htm

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Foreword from Dr. Eduardo J. Sanchez, Chair

Public Health Improvement Steering Committee,
Texas Commissioner of Health

Thank you for accepting the challenge to improve the health status of Texans by strengthening public health in Texas. It will take each member of our complex network of public, private, state, local, academic, volunteer, and service-delivery entities with numerous and widely varied functions (known as the public health system) working in coordination to meet this challenge. Nothing less than the future health of Texans depends on our efforts.

The work of the Texas State Strategic Health Partnership is focused on how to make public health the driving force to transform the state of the overall health of Texans. This Partnership is targeting its initial efforts on enhancing the *essential public health services* that benefit all Texans. Once this foundation is firmly in place, members of the Partnership can begin to address access to health care issues. We have taken this approach because without a viable, effective and efficient public health system that works, first, in the interest of the common good and, then, in tandem with the rest of the health care system, we will be at risk in the short and long term.

The health risks facing Texans today are numerous. By identifying 12 priority public health improvement goals, the Partnership has set priorities for members of the public health system to focus and coordinate their efforts. By working together, we can achieve maximum impact on the health of the population. For example, under Goal A, educating youth about the health benefits of increased physical activity and better nutrition will lead to a reduced risk of obesity in their adult years, thus preventing the sometimes devastating effects of obesity.

The state cannot afford to wait to move to a collaborative model of public health improvement because it will not be able to afford to take care of those afflicted with preventable diseases as the costs of those diseases mount. In addition to the human toll diseases inflict on individuals, the state's productivity and economic viability will be jeopardized and the overall quality of our life will be affected. So we have to move now to make prevention of diseases and illnesses through the public health system a cornerstone of state public policy. If we do so, the *physical* health of Texas will not endanger its *fiscal* health.

As you gather with other public health partners to develop plans to achieve these goals, remember that all partners play important yet different roles in promoting public health as the foundation for the health care system of Texas. We can all support the cause: some by lending expertise through data and information; some by giving life to the goals through their day-to-day public health practice; some by engaging in the public policy process by which these shared priorities can shape the public health system; and some by creating coordinated community organizations focused on public health improvement. Speaking in a common voice based on these 12 shared public health priorities, each partner can play a part in strengthening Texas' public health system.

Thank you again for accepting the challenge to improve the health of Texans.

THE TEXAS STATE STRATEGIC HEALTH PARTNERSHIP WORKGROUP INTRODUCTION

The health of a population is the shared responsibility of many entities, organizations, and interests including health service delivery organizations, public health agencies, and the people of a community. These entities are collectively called the public health system.

All the people of Texas deserve the assurance of a strong public health system. Despite a long history of successes by the public health partners in improving the overall health of the people of the state, critical health status challenges still exist in our rates of diseases, disabilities, premature deaths and other health threats.

The members of the public health system have agreed that the challenges facing the health of Texans must be addressed. Texas can no longer afford for partners of the public health system to work in isolation. When these partners work relatively independently of each other, Texas misses the impact of focusing resources and efforts on common goals. We must work together to improve the health of Texans.

In 2002 the Texas Department of Health (TDH) stepped forward to convene partners in the public health system to identify shared priorities and actions for improving the health of Texans. On October 1 and 2, 2002, the Commissioner of Health hosted a meeting of a wide-ranging group of partners in the public health system, the Texas State Strategic Health Partnership. Led by a 17-member Public Health Improvement Steering Committee, the Texas State Strategic Health Partnership recommended six goals to improve state health status and six goals to improve the public health system by 2010. The goals were finalized after two rounds of public comment. (A list of the members of the Steering Committee, the 12 goals, and some of the background materials from the goal-setting process are found in Appendix A.)

Workgroups are being established for each of the 12 goals. Each workgroup is co-chaired by two individuals, one of whom represents the Public Health Improvement Steering Committee and one who represents community-based public health interests. Workgroup members are partners from the public health system with interest in contributing to the achievement of the workgroup goal.

The materials that follow are designed to provide guidance and support to the workgroups in the Texas State Strategic Health Partnership as they take groundbreaking steps to improve the health of Texans.

For the latest information about progress of the workgroups, visit the website: http://www.tdh.state.tx.us/dpa/sshp.htm.

TEXAS STATE STRATEGIC HEALTH PARTNERSHIP

CHARGE FROM STEERING COMMITTEE

Steering Committee Charge to Workgroups:

To develop recommendations for how best to achieve each goal. The following should be included in a report to the Steering Committee in September 2003.

- What is the problem? Provide an evidence-based description of the issue voiced by the goal statement.
- What are the strengths, weaknesses, opportunities and threats related to this issue?
- What are the commitments the partners currently bring toward achieving the goal?
- What are the options for solutions? Optimally these options should be grounded in evidence-based best practices and relevant to state and local level implementation. This includes, but is not limited to issues requiring legislative action.

At the October 30, 2002 meeting, the Public Health Improvement Steering Committee identified a subcommittee to develop and plan the next steps for the Partnership. This subcommittee is now called the Executive Committee. The Executive Committee supports the Steering Committee by developing and monitoring the administrative and logistical functions of the Partnership. All major decisions about the Partnership are taken to the Steering Committee.

Members of Executive Committee are available for guidance and support to all workgroup co-chairs.

	Contact information
Camille Miller, Committee Lead	Texas Institute for Health Policy Research P.O. Box 15587 Austin, Texas 78761-5587 512/465-1041 cmiller@healthpolicyinstitute.org
Claudia Blackburn	Representing Texas Association of Local Health Officials Amarillo Health Department 1411 Amarillo Blvd. E. Amarillo, Texas 79105 806/351-7220 claudia.blackburn@ci.amarillo.tx.us
Hardy Loe	Representing Texas Public Health Training Center University of Texas School of Public Health 1200 Herman Pressler, P.O. Box 20186 Houston, Texas 77225 713/500-9493 Hloe@sph.uth.tmc.edu

Klaus Kroyer Madsen	Representing Texas Alliance for Healthy Communities Texas Institute for Health Policy Research P.O. Box 15587 Austin, Texas 78761-5587 512/465-1039 kmadsen@healthpolicyinstitute.org
Patti Patterson	Representing Texas Medical Association's Council on Public Health Vice President for Rural and Community Health, Texas Tech University Health Science Center 3601 4th Street, Suite 2B-440 Lubbock, Texas 79430 806/743-1338
Ann Pauli	Paso Del Norte Health Foundation 1100 N. Stanton, Suite 510 El Paso, Texas 79902 915/544-7636 apauli@pdnhf.org

Role of Texas Department of Health (TDH) Staff

- A core of TDH staff provides administrative support to the Partnership. This includes: enabling communication by maintaining the Partnership website and assisting the Steering Committee with administrative functions for the Partnership.
- TDH staff may be assigned to each Partnership workgroup to provide technical expertise on the subject matter of the goal. This activity may include providing information, referring the workgroup member to other resources, and participating in workgroup discussions.

If you have specific questions, please contact the following TDH staff. Each person below can be reached by phone at 512-458-7261.

Primary Contacts

- Rick Danko (email Rick.Danko@tdh.state.tx.us)
- Donna Nichols (email Donna.Nichols@tdh.state.tx.us)

Secondary Contacts

- Gyl Kovalik (email Gyl.Kovalik@tdh.state.tx.us)
- Hallie Overton (email Hallie.Overton@tdh.state.tx.us)

Contact for administrative information (e.g., communication with Executive or Steering Committee members, lists of partners, etc.)

- Amanda McNeese (email Amanda.McNeese@tdh.state.tx.us)

EXPECTATIONS FOR WORKGROUP CO-CHAIRS

- To identify potential workgroup members.
- To contact potential workgroup members to discern their interest in serving.
- To identify and invite collaboration of organizations or groups that already have projects in progress related to the respective goal.
- To convene/organize meetings of the workgroup.
- To assist with the selection of a graduate student, from a pool of graduate student applicants (when available), who will perform research on the issues.
- To assist with the development of a research plan for a graduate student.
- To work with the workgroup in answering the following questions:
  - ✓ What is the problem? Provide an evidence-based description of the issue.
  - ✓ What are the strengths, weaknesses, opportunities and threats related to this issue?
  - ✓ What are the commitments the partners currently bring toward achieving the goal?
  - ✓ What are the options for solutions? Optimally these options should be grounded in evidence-based best practices and relevant to state and local level implementation. This includes, but is not limited to issues requiring legislative action. (These topics will be the core information in each workgroup's final report to the Public Health Improvement Steering Committee.)
- To communicate regularly with and provide administrative support to workgroup members through development of agendas, scheduling conference calls or meetings, drafting notes of meetings, and development of other work group products.
- To work with workgroup members according to the principles for collaboration established by the Joint Council of State and Local Health Officials (see Appendix B).
- To review and give timely feedback on draft reports/communications from the workgroup.
- To provide regular progress updates to the Steering Committee, including any issues that require guidance/decisions from the Steering Committee.
- To serve through November 2003.

CRITERIA FOR WORKGROUP CO-CHAIRS

- One co-chair must be a member of the Steering Committee.
- One co-chair must be active in local level public health (community, municipality, county, or regional-- "where the rubber meets the road").
- Collectively, co-chairs should represent Texas' diversity in geographic distribution, rural/urban representation, race/ethnicity, gender, and professional level.
- Collectively, co-chairs should represent the breadth of types of public health partners (public, private for-profit and not-for-profit, voluntary, academic, etc.).

EXPECTATIONS FOR WORKGROUP MEMBERS

- To assist the workgroup co-chairs in making the workgroup successful (see workgroup co-chairs expectations).
- To help identify and invite collaboration of organizations or groups that already have projects in progress related to the respective goal.
- To attend meetings of the workgroup—via teleconference or in person.
- To assist with the development of a research plan for a graduate student who will perform research on the issues (optional).
- To work with the workgroup in answering the following questions:
  - ✓ What is the problem? Provide an evidence-based description of the issue.
  - ✓ What are the strengths, weaknesses, opportunities and threats related to this issue?
  - ✓ What are the commitments the partners currently bring toward achieving the goal?
  - ✓ What are the options for solutions? Optimally these options should be grounded in evidence-based best practices and relevant to state and local level implementation. This includes, but is not limited to issues requiring legislative action.
- To work with workgroup members according to the principles for collaboration established by the Joint Council of State and Local Health Officials (see Appendix B).
- To communicate via email, fax, or phone as needed with workgroup co-chairs/ members.
- To review and give timely feedback on draft reports/communications from the workgroup.
- To serve through November 2003.

NOTES FOR ALL WORKGROUP MEMBERS:

Time Commitment

- Time commitment of workgroup participants will vary by workgroup and/or by month but workgroup members should anticipate an average of 2-3 hours per month.
- Time commitment of co-chairs will be slightly higher due to organizational/ administrative responsibilities to the workgroup.

Meetings and funding

- Workgroup members will determine the meeting schedule necessary to conduct workgroup business.
- Given the limited resources of all public health partners, most or all workgroup meetings may be held by conference call.
- Although the majority of meetings will be held by conference call, in-kind contributions of partner organizations are necessary to cover any travel expenses that may arise. The Texas Department of Health will not reimburse travel expenses of workgroup members.

WORKGROUP GENERAL GUIDELINES

January – February 2003
Establish workgroup co-chairs and members.

- Recruit a broad and diverse set of representatives for the work group. Draw from participants at the October 1-2, 2003 planning session at the Capitol. Draw from organizations that provided Commitments.

February – April 2003
Research background and relevance of goal to public health

- Include best practices at local, state, and federal levels to achieve goal.
- Identify stakeholders who are affected by or involved in achieving the goal.

May – July 2003
Formulate implementation plan

- Identify objectives and strategies to achieve goal in Texas
- Describe methods for funding and marketing the policy/program/intervention.
- Identify appropriate methods for monitoring results (are there measurable outcomes to track goal achievement over time?).

Late May 2003
Report in workgroup co-chair conference call

- A conference call will be held to communicate about progress and problems faced by all workgroups.

July – September 2003
Prepare report and submit to Steering Committee on September 1, 2003.

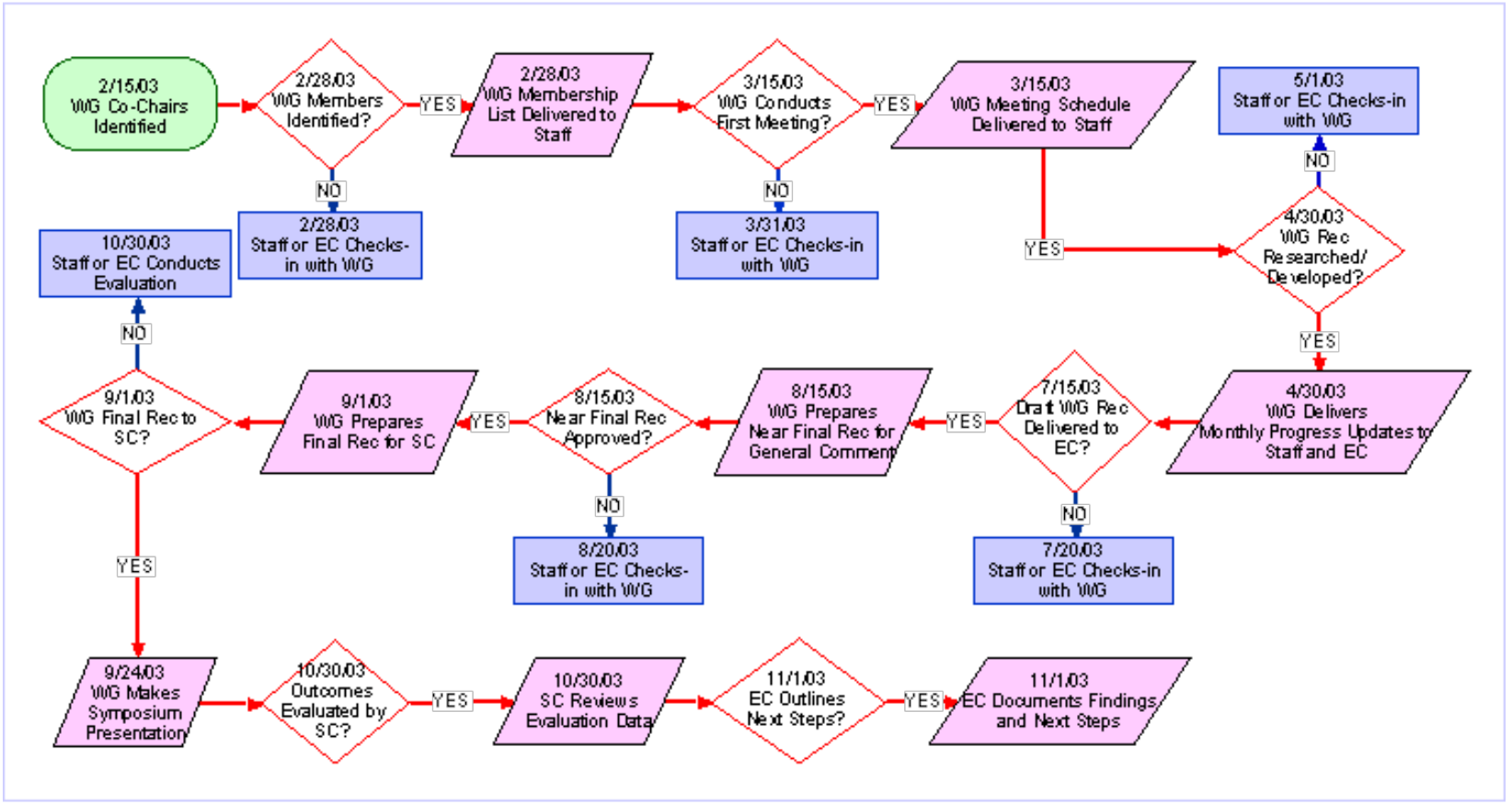
- Submit draft of report to Executive Committee on July 15, 2003.
- Submit revised draft by August 15, 2003 for comment period on website.
- Report to include general findings and options for addressing each goal.

September 24-25, 2003
Report in at the symposium hosted by the Texas Institute for Health Policy Research in Austin.

- At this symposium, each workgroup will present the findings and recommendations for the achievement of their goal from their final report.

Key Milestones:
2/28/03 – Workgroup members identified
3/15/03 – workgroup holds first meeting
4/30/03 – Initial draft of background research and recommendations developed
7/15/03 – Draft of workgroup report submitted to Executive Committee
8/15/03 – Near-final draft of workgroup report submitted
9/1/03 – Final report submitted to Steering Committee
9/24-25/03 – Workgroup makes presentation at Symposium
10/30/03 – Outcomes evaluated by Steering Committee
11/03 – Steering Committee outlines next steps

Texas State Strategic Health Partnership
Work Group Communications Flow Chart



KEY: EC =Executive Committee
Rec =Recommendations
SC =Steering Committee
Staff =TDH Staff
WG =Work Group

LEGEND: Start, Decision, Process, Deliverable

2/10/03

TEXAS STATE STRATEGIC HEALTH PARTNERSHIP

PROPOSED WORKGROUP WORK PLAN

Each workgroup is asked to submit a report with recommendations for how to achieve its public health improvement goal. This work plan outlines the key steps each workgroup should take in developing its report.

WORKGROUP NAME				
Task Name	**Task Description**	**Measurable Task Objectives**	**Outcomes Objectives**	**Timeline**
1. Define relevance and justification	Explain relevance of partnership goal to public health. What does the evidence tell us about the importance of this goal?			
2. Research topic	Research what best practices exist at local, state and federal levels to meet the goals and objectives.			
3. Describe stakeholders	Describe stakeholders (e.g., community groups, organizations and other professionals) who are affected or involved in resolving the issue. Are the stakeholders part of the Partnership? If not, describe out reach strategies.			
4. Specify goals and objectives	Outline the major goals and objectives the workgroup seeks to achieve through the proposed policy or program.			
5. Develop implementation plan	Formulate a plan for implementing, funding and marketing the policy, program or intervention.			
6. Draft recommendations	Recommend how the Strategic Health Partnership should continue its work on this particular goal. More than one option may be identified.			
7. Evaluation	Suggest mechanisms appropriate for evaluating and monitoring the policy or program's results.			

Workgroup Monthly Updates

Workgroups will provide monthly updates to the Steering Committee, through the Executive Committee.

- Monthly reports will be posted on the partnership website.
- Updates should be brief (one page) and follow this template.

Goal #: Title, (month) 2003

Co-Chairs: _____ (Phone and email) and _____ (Phone and email)
(note: emails will only be posted on Internet with permission)

Recent Activities and Accomplishments

- *In bullet form, list the recent activities and accomplishments of the workgroup, including meetings held.*

Upcoming Events or Activities

- *In bullet form, list the planned activities or events of the workgroup.*

Challenges to Accomplishing Workgroup Objectives

- *In bullet form, identify the challenges the workgroup has faced and the strategies used to overcome them.*

Need for Assistance

- *In bullet form, communicate any need for assistance or trouble-shooting from the Executive Committee or Steering Committee.*

Appendix A: Background Materials

Background materials include:

- The Declaration for Health, signed on December 4, 2002 by the Public Health Improvement Steering Committee.
- The 12 public health improvement goals identified by the Texas State Strategic Health Partnership.
- The two briefings for discussion, which provide basic assessments and a discussion of the issues surrounding of health status and Texas' public health system.
- The essential public health services, listed here as they were codified in state law.

Texas Declaration for Health

To fully enjoy the benefits of a prosperous and growing state, Texans and their communities must be healthy. Disparities in health among the people of Texas are not acceptable. The public health system must be effective and efficient in preventing disease and protecting all Texans from health threats.

We, the organizations affixing our signatures to this declaration, represent the length and breadth of Texas. We believe the public health system is the cornerstone of our state's health care system. We believe that the public health system can and must be improved to better meet the needs of all Texans.

Recognizing that "public health" includes all the activities that society undertakes to assure the conditions in which people can be healthy, and that health improvement depends on the actions of individuals, communities, and public and private partners, we, the undersigned, pledge to work together and share responsibility and accountability for creating a healthier Texas by the year 2010.

We must promote healthy eating and safe physical activity.

We must reduce the disease, disability, and premature death that result from tobacco use, risky sexual behavior, substance abuse, and violence.

We must promote mental health and individual and community social connections to improve prevention, early detection, and treatment of mental disorders.

We must increase the rates of high school graduation, adult literacy, college attendance, and other advanced education and training to improve socioeconomic and health status.

We must reduce health threats caused by environmental and consumer hazards.

We must take steps to reduce infectious diseases by raising rates of timely immunizations for children and adults.

We must change state statutes and local policies to ensure that essential public health services are available for all Texans.

We must build a system of collaborative partners to provide necessary public health services.

We must inform every community in Texas of the function, purpose, and availability of the state's public health system.

We must train the workforce of the public health system to meet evolving public health needs.

We must create a flexible funding system that supports public health.

We must base decisions on state and local level health indicators obtained through a reliable data collection and reporting system, while protecting the privacy of Texans.

We, the undersigned, dedicate ourselves to the cause of public health and to the community called Texas, and to its future. We urge our fellow Texans to join us in this vital mission.

Steering Committee Members

Texas Department of Health
Commissioner of Health Eduardo Sanchez, MD, MPH (Chair)
Texas Health and Human Services Commission
Pat Devin
Texas Education Agency
Tom Fleming, PhD
Health Disparities Task Force
Adela Valdez, MD
Texas Environmental Health Association
Elise A. Dixon, REHS/RS
Paso Del Norte Health Foundation
Ann G. Pauli
Texas Health Foundation
Robert Bernstein, MD
Preparedness Coordinating Council
Charles E. Bell, MD
Texas Institute for Health Policy Research
Camille Miller, MSW
Texans Care for Children
Stephen Barnett, MD
Texas Medical Association Council on Public Health
Patti Patterson, MD, MPH
Texas Alliance for Healthy Communities
Klaus Kroyer Madsen
Texas Nurses Association
Clair Jordan, MSN, RN
Texas Association of Counties
Sue Glover
Texas Public Health Association
John Herbold, DVM, MPH, PhD
Texas Association of Local Health Officials
Claudia Blackburn, RNC, MPH
Texas Public Health Training Center
Hardy D. Loe, Jr, MD, MPH

Twelve Goals for 2010

Goal A: Improve the health of all Texans by promoting healthy nutrition and safe physical activity.

Goal B: Promote healthy choices with regard to risky behaviors including, but not limited to, tobacco use, risky sexual behavior, substance abuse, and violence to reduce the disease, disability, and premature death resulting from unhealthy choices.

Goal C: Recognize mental health as a public health issue. Promote mental health and increase individual and community social connections in order to improve prevention, early detection, and treatment of mental disorders.

Goal D: Increase rates of high school graduation, adult literacy, college attendance, and other advanced education and training thereby improving socioeconomic and health status.

Goal E: Reduce health threats due to environmental and consumer hazards.

Goal F: Reduce infectious disease in Texas with a focus on increasing rates of timely immunization among Texas children and adults.

Goal G: By 2010, Texas state statute and local policy will ensure that essential public health services (emphasizing disease/injury prevention and health promotion) are available for all communities in Texas.

Goal H: By 2010, a diverse set of governmental and non-governmental partners will actively participate and collaborate to provide the services necessary to meet the public health needs of Texans.

Goal I: By 2010, Texas communities will be aware of the structure, function and availability of the public health system.

Goal J: By 2010, the public health system workforce will have the education and training to meet evolving public health needs.

Goal K: By 2010, the Texas public health system will be operating with a flexible funding system that efficiently and effectively meets the needs of communities for all public health objectives.

Goal L: By 2010, the Texas public health system partners will be informed by, and make decisions based on, a statewide, real-time, standardized, integrated data collection and reporting system(s) for demographic, morbidity, mortality, and behavioral health indicators accessible at the local level which also protects the privacy of Texans.

Current Health Status in Texas

The key to good health for all Texans is creating a culture of health and fitness in which individuals *and* communities make healthy choices as a matter of course. Texans are doing better than the national average in avoiding some **health risks**; however, for other risk behaviors, Texans lag behind the national average. Below are some key health risk statistics from surveys conducted in various years from 1999-2001:

- 22% of adult Texans are smokers (23% nationally),
- 25% of Texas high school students are current smokers (28% nationally),
- 23% of Texas adults are obese (20% nationally); an additional 37% of Texas adults are overweight (additional 37% nationally),
- 14% of Texas high school students are overweight or obese (11% nationally),
- 29% of Texas adults are physically inactive (27% nationally),
- 35% of Texas high school students do not participate in sufficient physical activity (35% nationally),
- 18% of Texas adults reported binge drinking (15% nationally),
- 49% of Texas high school students reported current alcohol use (47% nationally),
- 10% of Texas adults reported past-year illicit drug use (10% nationally),
- 41% of Texas high school students had used marijuana during their lifetime (42% nationally),
- 44% of Texans aged 65 and older had never received a pneumococcal vaccination (45% nationally),
- 23% of Texas women aged 40 and older had never received a mammogram and breast exam (18% nationally).

Research has shown that poor health behaviors such as smoking, sedentary lifestyles, drug and alcohol abuse, and failure to access health screenings often lead to disease or injury and/or they can aggravate the negative impacts of disease. In addition, poor health behaviors and their negative health effects are costly. For example, tobacco use costs the

state of Texas more than $10 billion annually. Tobacco use is a contributor to all of the leading causes of death in Texas.

In 2000, the **leading causes of death** in Texas were disease of the heart, cancer, stroke, accidents (unintentional injuries) and chronic lower respiratory disease (CLRD), in that order. In 2000, the **leading causes of premature death** (before age 65) in Texas were accidents and adverse effect, malignant neoplasms, diseases of the heart, conditions originating in the perinatal period, and suicide, in that order.

Aggregate statistics are important to understanding the overall health of the population but they sometimes obscure **key disparities** among population groups in a larger population. In TDH's July 2002 *The Health of Texans* report, many disparities among the three largest racial/ethnic groups and between males and females in Texas were described. Some of the most striking disparities include:

- Death rates from coronary heart disease (CHD) are highest among African Americans and Texas males have twice the risk of dying from CHD as females.
- Overall cancer rates are highest among African Americans, then whites, then Hispanics.
- African Americans have the highest mortality rates for strokes, then whites, then Hispanics.
- Mortality rates for diabetes for African Americans and Hispanics are 2-3 times higher than for whites.
- 80% of persons affected by osteoporosis are women.
- HIV and AIDS affect African Americans more than Hispanics and whites and men more than women.
- The infant mortality rate for African Americans is more than twice the rate for whites and Hispanics and the percentage of low birth weight babies born to African Americans is almost twice that for Hispanic and white women.
- Nearly twice as many women as men suffer from a depressive disorder.
- Whites are more than twice as likely to commit suicide than African Americans or Hispanics and men commit suicide more often than women.

Some other health status challenges in Texas are important to consider in painting an overall picture:

- Texas has experienced high levels of morbidity from pertussis, a highly-contagious, vaccine-preventable disease, with more than 765 cases reported to date in 2002. The pertussis morbidity is symptomatic of a larger childhood immunization problem in Texas. According to the 2001 National Immunization Survey, Texas ranks 42nd among the 50 states for the series of vaccines that included pertussis for children aged 19-35 months with only 74.9 percent immunized.
- In 2001, Texas experienced increases in reported AIDS cases, syphilis, and tuberculosis, ending downward trends for all three in the years preceding.
- Border counties in Texas experience higher tuberculosis and neural tube defect incidence than the rest of the state as well as many other disproportionate health burdens.
- The unintentional injury mortality rate has increased in Texas since 1994 and unintentional injuries are the leading cause of death for Texans aged 1-34.

Challenges to Improving the Health Status Quo

Funding: Only 5% of the trillion dollars spent nationally on health goes to population-based approaches to health improvement while 95% goes to direct medical services. In addition, different standards are often applied to interventions to improve population health versus medical treatments. Medical treatments need only be considered safe and effective while health promotion efforts are required to show evidence that future savings offset investments. Sometimes prevention will save money and sometimes not, but the body of evidence is growing that many prevention efforts improve quality of life and health status of populations.

Workforce: Given the spending formula described above, it is not coincidental that the health workforce is trained to focus on medical treatment of individuals with disease versus promotion of health behaviors in individuals and communities. Interest groups promoting medical care and research around specific diseases and medical professionals with strong ethical training and financial incentive to provide medical care are organized lobby groups for medical care while a similar organized lobby for population health promotion does not exist.

Environmental challenges: Education, employment, income disparities, poverty, housing, crime, health infrastructure, and social support systems are crucial to an

individual's and a population's health. For example, level of education is the best predictor of the likelihood of death in any given year. In addition, pollution in the air, water and soil as well as structural hazards where we live, work and play contribute to health problems of the population. For example, half the Texas population lives in urban areas that exceed federal guidelines for ozone.

Behavioral factors: As discussed above, behaviors are key to improving health. Many people do not want to change their behaviors even when they are aware of the risks; individual interventions are costly and are, by definition, relatively short-term. Individual health choices cannot alone improve community health. Communities in which policies (laws, regulations, and rules) and environments (economic, social or physical) support healthful living will enjoy a greater culture of health and fitness. Policy and environmental change interventions are a new area of activity for traditional public health practitioners that they are sometimes not comfortable with, not skilled in addressing, or unable to address because of competing financial and programmatic priorities.

Data and research: Understanding the health of Texans depends on data that are current, accurate, comparable over time and location, and easily accessible. For some important diseases or health conditions in Texas and for some racial/ethnic and geographical sub-populations, the available data do not meet these criteria. Some of the data gap exists because there are not resources to collect and make the data available at all or in a timely and accessible manner. Some of the data gap is because research to date has not answered important questions. For example, what are the dynamics of genetic predisposition and environmental factors in causing disease processes to start or accelerate? Why do some racial/ethnic disease differences exist even after controlling for social and economic factors?

Complexity of interventions: Generally health status is shaped by factors in five areas: social circumstances, environmental conditions, behavioral choices, genetic factors, and medical care. Potential health improvement interventions range from medical treatment for individuals with existing diseases to broad population-based prevention, with varying benefits and costs associated with each. While public health practice strives to find and use the interventions with the "biggest bang for the buck," decisions about the prioritization of interventions and the allocation of resources among them are made daily—sometimes in the absence of formal public policy guidance.

Conclusion

A variety of diseases, health conditions, and risk factors pose critical challenges to health status in Texas. Public health practice has effective interventions for reducing or even preventing some of these health challenges, but resources are finite and consensus has not been sought on priorities. In this situation, Texas misses the impact of focusing limited resources and efforts toward reaching common health status improvement goals.

What will the picture of health in Texas look like in 2010?

Sources

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2. McGinnis JM, Williams-Russo P, Knickman JR. The Case for More Active Policy Attention to Health Promotion. *Health Affairs*. 2002; 21(2): 78-93. Available at: http://130.94.25.113/1130_abstract_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n2/s12.pdf. Accessed September 19, 2002.
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4. U.S. Centers for Disease Control and Prevention. National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19-35 Months—United States, 2001. *Morbidity and Mortality Weekly Report.* August 2, 2002; (51)30: 664. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5130a2.htm. Accessed September 19, 2002.

Briefing for Discussion: The Public Health System

Prepared by Texas Department of Health, October 1, 2002

A strong, flexible, and coordinated public health system is the key to ensuring the health of all Texans and Texas communities and is the best defense in any public health emergency. The past year's efforts to establish a coordinated network of preparedness against bioterrorism met with notable successes in Texas, thanks to the combined efforts of many public and private sector players at the state and local levels. Yet even as partners across the state rallied around the need for a strong and capable public health system, many of the ongoing challenges[1] that characterize Texas' diffuse public health infrastructure emerged anew.

All the people of Texas deserve the assurance of a system that works day to day to protect, promote, and improve health. Among the strengths and weaknesses of the current system are opportunities for further progress toward that assurance.

A note about the public health system: Public health practice comprises the "activities that society undertakes to assure the conditions in which people can be healthy… [which] includes organized community efforts to prevent, identify, and counter threats to the health of the public."[2] The health of a community is the shared responsibility of many entities, organizations, and interests in the community including health service delivery organizations, public health agencies, and the people of a community. The partners of the **public health system** that work to improve the health of communities are a diverse and complex network of public, private, state, local, national, international, academic, volunteer, and service-delivery entities with numerous and widely varied functions. This State Strategic Health Plan focuses attention on the public health system that is geared toward protecting **the health of the population as a whole** (related to the varied set of activities that practitioners and Texas state law[3] call the "**essential public health services**"). The important (and even more complex) system of medical services for individuals is beyond the scope of this plan.

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[1] *The State of Public Health: Local and State Government Issues in Texas*. Report Resulting from House Concurrent Resolution 44 of the 75th Legislature. December 1998.
[2] Turnock BJ. *Public Health: What It Is and How It Works*. Gaithersburg, MD: Aspen; 1997:375.
[3] Health and Safety Code Chapter 121

Current Status of the Public Health System in Texas

Through their widely varied approaches to the public's health, the partners in Texas' public health system all play unique, yet critical roles in protecting, promoting, and improving the health of the public. Currently, each of these partners operates primarily within its own field (or system), providing important services related to distinct aspects of Texans' health. The independence of the partners (both across governmental entities and among governmental and non-governmental entities) makes it difficult to recognize the roles of all partners as members of a "single" public health system, whether at the local, regional, or state level. Attempts to describe the operations of different aspects of the larger public health system most often result in focused descriptions of the operations of the parts rather than a broad description of the coordinated operations of the whole system. Resources—whether in terms of workforce, knowledge base, material, or financial—are scattered throughout and are not always clearly labeled as "public health." As a result of this diverse and diffuse system, it is difficult to know if Texans in different communities enjoy the same level of assurance of conditions to support their health.

Some public health functions that assure healthy conditions are inherently governmental roles, while others are not. Mandates throughout state statutes (and in some cases, federal statutes) define programs and services Texas Department of Health (TDH) provides. In general terms, the TDH has been given the broad responsibility to meet the health needs of the state by the Texas Legislature.

- "The Texas Board of Health and the Texas Department of Health are established to better protect and promote the health of the people of the state" (Health and Safety Code 11.002).
- "The board has general supervision and control over all matters relating to the health of the citizens of this state" (HSC 12.001).

The state law that enables the creation of local health departments does not require local governments to establish health agencies[4], nor does it prescribe the services they provide. Each local agency operates independently of the state, has independent legal authority, and offers different types and levels of service.

[4] Health and Safety Code Chapter 121.

The non-governmental partners in the system came into being for a variety of reasons, usually to fill a niche or meet a specific need: as private foundations or community-based organizations targeting specific diseases or health conditions; as part of a university/higher-education system; as part of the health care delivery system; etc.

Texas became the first state in the nation to codify the essential public health services when HB 1444 (76th Legislature) defined them in Chapter 121 of the Health and Safety Code. The essential public health services reflect the range of activities in which any public health system engages to protect and promote the health of a population. Codification of the essential public health services may provide a common language and mission for the work of the public health system.

Challenges to Improving the Public Health System Status Quo

Diffuse nature of the system: Texas' public health system, as described above, is decentralized and complex. Each level of Texas' governmental public health system currently operates according to its respective mandates and in response to identified health needs. For many of these entities, changing the system depends on new legislation or local policies. Each non-governmental partner in the public health system operates (largely) independently to achieve its own mission and goals.

Undifferentiated roles and responsibilities: The laws that create governmental public health agencies do not always specify the unique roles of local, regional, or state-level (or even federal) members of the system. Local communities (municipalities, counties, or districts) may establish a public health department, but are not required to provide any specific set of services (HSC 121). For the counties in Texas that do not have a local governmental public health agency, TDH's eight regional operational headquarters provide basic and necessary essential public health services. Progress has been made to define the roles of each level more clearly (for instance, more clarity has been brought to the responsibilities of local health authorities), but more work remains.

Funding: Funding for the development of a system that supports prevention efforts (rather than curative care) has not been consistently prioritized. Funding that is available either from government or from foundations is most commonly focused on disease- or population-specific efforts. As the economic situation changes over time, the stability of funding varies.

Workforce: A competent workforce is at the heart of an effective public health system. As the public faces new and more complex health challenges, including environmental challenges, behavioral risks that lead to increasing rates of chronic and infectious diseases, and the increased threat of a bioterrorist attack, the need for a well-trained public health workforce has never been more pressing. Identification of the members of the public health workforce across the varied functions and roles of the public health system is a critical challenge to preparing that workforce. While a list of competencies based on the essential public health services exists, these competencies are not yet applied in public health practice as standard set of expectations of the workforce or as the basis for training.

Measuring Performance: In a complex system with many varied partners, some measures of performance and accountability are needed to find out first what capacity does exist, and then to ensure that the goals of the system are ultimately achieved. Measures of outcomes have been created in some communities in the form of health status indicator "report cards;" these require the prioritized selection of indicators and data systems that provide timely and specific information. Currently, there is no standard set of system performance measures in place either at the state or national level. Texas is examining models for local performance evaluation in a partnership between TDH and the Texas Association of Local Health Officials.

Establishing rationale for priority setting at local, regional, and state levels: Currently, each community (whether local, regional, or state) may or may not develop a rationale for setting priorities for action in that community. When a rationale for action is developed, it is likely to vary from one community to the next based on local values, resources, etc. Until the recent past, community leaders have had few tools to guide them through the priority setting process; still today, the number of available tools is extremely limited (and the health status summaries currently used face data constraints). Priorities set by each community can be very different depending on whether those priorities are based on the evidence about each community's health status or based on the community's perception of health risks.

Conclusion

The Texas Department of Health and its public health partners can look back on a long history of success in dramatically improving the overall health of the people of the

state. In many cases, this past success resulted from a common, focused effort to eliminate or prevent a health threat such as polio or yellow fever. The health issues we face today have become more complex and numerous, yet no coordinated effort currently exists to determine shared, statewide priorities for strengthening and improving the very system we rely on to protect, promote and improve the health of all the people of Texas. In this situation, Texas misses the impact of focusing limited resources and efforts toward reaching common goals.

What will the public health system in Texas look like in 2010?

The Essential Public Health Services

The essential services are the foundation of the governmental and non-governmental public health practice. Texas became the first state in the nation to codify the essential services when HB 1444 (76th Legislature) defined them in what became Chapter 121 of the Health and Safety Code. Though their impact ultimately touches individuals, they are mostly concerned with actions that are targeted at populations.

1. Monitor the health status of individuals in the community to identify community health problems.
2. Diagnose and investigate community health problems and community health hazards.
3. Inform, educate, and empower the community with respect to health issues.
4. Mobilize community partnerships in identifying and solving community health problems.
5. Develop policies and plans that support individual and community efforts to improve health
6. Enforce laws and rules that support individual and community efforts to improve health.
7. Link individuals who have a need for community and personal health services to appropriate community and private providers.
8. Ensure a competent workforce for the provision of essential public health services.
9. Research new insights and innovative solutions to community health problems.
10. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services in a community.

Appendix B: Principles of Collaboration Between State and Local Public Health Officials

Adopted by the Joint Council of State and Local Health Officials (National Association of City and County Health Officials and the Association of State and Territorial Health Officials), February 2000

Preamble:
Policy development comprises one of the three core functions of governmental public health. Policy development activities conducted at federal, state, and local levels include the development of plans, priorities, statutes, ordinances, resource allocation discussions, and program requirements (including operational and fiscal accountability policies). As policy is developed at one level of government with implications for other levels of government, it is important to avoid unintended policy conflicts while assuring that the policy will achieve intended outcomes. These principles, developed by the Joint Council and ratified by the Boards of ASTHO and NACCHO, are intended to promote effective policy development at the interfaces of state and local public health departments.

Principle One: Resource Allocation

- Principle 1A – Securing adequate resources for public health must be a joint responsibility between state and local health departments, and balance the needs of state and local service providers.
- Principle 1B – State and local health departments should work together to design strategies and plans for allocation of federal and state public health resources.
- Principle 1C – Resources should be allocated and services delivered as close to the location in need as possible, while considering other factors including economy of scale, accountability, and particular expertise.
- Principle 1D – Resource allocation decisions should give priority consideration to local and state infrastructure needs wherever possible to assure that essential capacities are in place.

Principle Two: Policy Development

- Principle 2A – Policies ought to be designed to provide the maximum benefit available to the health of the public.
- Principle 2B – State and local policies ought to be aligned to the maximum degree possible.
- Principle 2C – State policy planning and design efforts should incorporate the involvement of local public health agencies to assure a better fit with public health problems and needs.
- Principle 2D – State health department priority development processes should incorporate local participation to ensure that relevant priorities are selected.
- Principle 2E – State policy development should begin with sufficient advance notice to local and other partners to ensure adequate opportunities for local input and participation.
- Principle 2F – State and local health department officials should have candid meetings to discuss and communicate opportunities or limits imposed by governmental or political entities.

- Principle 2G – State and local health departments should work together to determine reasonable program reporting requirements.

Principle Three: Advocacy

- Principle 3A – Local public health agencies should make every attempt to stay current with state public health policy issues, and to advocate with local boards of health, state legislatures and other relevant bodies for state health department proposals, where feasible.
- Principle 3B – State and/or local health departments should form a means through which leadership of local health departments and/or state offices serving local communities can meet with each other periodically to share common issues including health policy issues (e.g. state associations of county and city health officials).
- Principle 3C – Representatives of local health departments or state offices serving local communities should meet periodically with leaders from the central office of the state health department, and other relevant state leaders, to discuss policy advocacy issues.
- Principle 3D – State and local public health agencies should become familiar with the state legislative process and the relationship between the administrative and legislative policy development processes.
- Principle 3E – State and local health officials and/or leaders of state and local public health agencies should provide information to administrative and legislative bodies to assure that local conditions and realities are considered in the development of health policy.

Principle Four: National Coordination

- Principle 4A – State and local public health officials should work together and in partnership with their national associations (ASTHO and NACCHO) to advocate for more state and local involvement in the development of national priorities, agendas and other forms of policy affecting state and local health departments.
- Principle 4B – Representatives of ASTHO, NACCHO, and the Joint Council should work with federal agencies to promote state and local participation in the development of national policies, which include, program design, funding allocation strategies, regulations and guidelines.